State of Idaho
Department of Health and Welfare

HW 1040
Rev. 8/1998

OPTIONAL REFERRAL FORM FOR NEWBORN MEDICAID COVERAGE

PART 1: TO BE COMPLETED BY THE MEDICAID PROVIDER

Provider's Name: _____

Street Address: _____

City/State/Zip: _____

IDENTIFYING INFORMATION:

A. **MOTHER'S NAME** (Last, First, MI) (**Required**): _____
(Copy of Medicaid I.D. Card may be substituted for name, address, SSN and Medicaid number of mother.)

Address: _____

Social Security Number of Mother (**Required**): _____

Medicaid Identification Number (if known): _____

Case Manager's Name (if known): _____

B. **INFANT'S NAME** (Last, First, MI) (**Required**): _____

Date of Birth (**Required**): _____ Sex of Baby (**Required**): Male / Female

Has application been made for a Social Security Number for the child? ❑ YES ❑ NO ❑ Unknown

C. **FATHER'S NAME** (Last, First, MI) (**Required**): _____

Mailing Address: _____

SSN of Father: _____ Phone Number: _____

_____ _____
Signature of Provider/Provider Representative Completing Part 1 Phone Number

PART 2: TO BE COMPLETED BY THE DEPARTMENT OF HEALTH AND WELFARE AND RETURNED TO THE MEDICAID PROVIDER.

A. Infant's Medicaid Identification Number: _____

B. Effective Date of Child's Medicaid Eligibility: _____

C. DHW Person Furnishing Information (Print Name): _____

_____ _____ _____
Signature Phone Number Date

Distribution upon Referral: Pink Retained by Provider.
All other copies to DHW field office.

Distribution upon Completion: White returned to Provider.
Yellow in DHW case record.